

Please complete this form and submit with all required information and attachments to be considered for reimbursement. Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state or federally funded programs, nor for any amount covered by insurance, FSA or HSA - none of which are eligible for payment.

Patient Information																																							
Name (Last, First): _____		Address (Street): _____																																					
Apt./Suite No. _____	City: _____	State: <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Zip: <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/> <input style="width: 25px;" type="text"/>																																					
Email: _____ @ _____		Phone: (<input style="width: 20px;" type="text"/>) _____ - _____																																					
Fax: (<input style="width: 20px;" type="text"/>) _____ - _____																																							
(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)																																							
<div style="border: 1px solid black; padding: 5px;"> Please refer to the OPUS Health box, found on your card or printed offer, for the required information. It will look similar to the example shown (right). </div>	<table border="1" style="font-size: small; border-collapse: collapse;"> <tr><td>OPUSHEALTH </td></tr> <tr><td>Bill Primary Insurance First</td></tr> <tr><td>RxBIN: 601341</td></tr> <tr><td>RxPCN: OHS</td></tr> <tr><td>RxGrp: OH0000000</td></tr> <tr><td>RxID: 000000000000</td></tr> <tr><td>Suf: 01</td></tr> </table>	OPUSHEALTH	Bill Primary Insurance First	RxBIN: 601341	RxPCN: OHS	RxGrp: OH0000000	RxID: 000000000000	Suf: 01	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">RxGrp#: <input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></td> <td style="padding: 5px;"><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></td> <td style="padding: 5px;"><input style="width: 20px;" type="text"/><input style="width: 20px;" type="text"/></td> <td style="padding: 5px;"><input style="width: 20px;" type="text"/><input style="width: 20px;" 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<input type="checkbox"/> Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.																																							

Insurance Information
Do you have Health Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes and my insurer for prescription benefits is: _____ My insurance covered: <input type="checkbox"/> This entire prescription <input type="checkbox"/> None of this prescription <input type="checkbox"/> All except copay of: \$ _____ This prescription was filled at <input type="checkbox"/> a retail pharmacy store, <input type="checkbox"/> through mail order or specialty pharmacy (EOB required)* *Specialty/Mail order claims require a copy of the Explanation of Benefits for this prescription from your insurance provider.

Pharmacy Receipt	
Mail this completed form <u>along with the following items</u> to the following address: <div style="text-align: center; padding: 10px;"> OPUS Health, Attn: Card Processing Department 1324 Motor Parkway, Suite 105, Hauppauge, NY 11749 </div> <ol style="list-style-type: none"> 1. The original pharmacy receipt received from your pharmacy with your Rx, (Cash register receipts are NOT acceptable) which must include the following information (see sample receipt, right): <ul style="list-style-type: none"> ✓ Patient name and address ✓ Pharmacy name, address and phone ✓ Doctor or health care provider name, address and phone ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity ✓ Overall prescription price and Copay amount/out of pocket expense paid 2. Copy of your EOB (if required as stated in Insurance Information section above) 	<div style="border: 1px solid black; padding: 5px; font-size: small;"> <p style="text-align: center;">RECEIPT OPUS-ISM PHARMACY 1324-106 MOTOR PARKWAY HAUPPAUGE, NY 11749</p> <hr/> <p>Rx:100053 Filled:03/31/05 SMITH, JOHN Q (CC) 123 MOTORPARK WAY HAUPPAUGE, NY 11788 OFI</p> <p>MYDRUG 120 MG Qty:30 NDC:00000000000 No Refills NO AUTHORIZATION REQUIRED</p> <p>DR. JONES, TOM 1324 MOTOR PARKWAY, HAUPPAUGE, NY 11788 AA0000000 (631)582-6787</p> <p style="text-align: center;">RxPrice:\$xxx.xx</p> <p style="text-align: center;">THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.</p> </div>

Certification Statement
<p>“I, _____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law.”</p> <p>Claimant/Patient/Legal Guardian Signature: _____ Date: _____</p>

Please allow 3 – 5 weeks for processing. This form can be used for multiple submissions.
For assistance completing this form, contact OPUS Health at 1-800-364-4767 and select the Patients option.